Music Therapists Experiences Working in a Setting that Values Censorship: An Interpretative Phenomenological Analysis

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Abstract

This qualitative study examined the experiences of music therapists that work in an environment that promotes censorship practices. There are several studies that discuss censorship practices across helping professions but few studies within music therapy literature. Music therapy code of ethics and education stress the importance of self-reflection and recognizing biases for the therapist, however there is minimal information on biases when applying censorship practices. As a helping profession nonmaleficence is emphasized, however there is a paucity of research that includes the relationship between harm and censorship. Additionally, music therapy research and education identifies the need for culturally responsive practices, however have not included censorship and its effects on the therapist and participants in this movement. In this study seven participants engaged in one semi-structured interview to describe their experiences and relationships with self, clients, coworkers and larger institutions when experiencing censorship practices. Results demonstrate three overarching themes of values and beliefs, responses and navigating power in relationships. Each theme had at least three levels which described the experience of the client, therapist, co-workers and institution. These narratives and results suggest the need for continued research and discussion in the music therapy community on harm that may occur through censoring songs and experiences and ethical implications.

Keywords: mental health, censorship

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inspired by the relationship between you and students where we learn from each other, promote accountability and strive for equity in our personal and professional relationships.

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Introduction:

Motivation for Research:

As an undergraduate student I had the opportunity to work with a variety of people, abilities, needs and cultural backgrounds. Despite working with a range of people and subsequent broad musical styles, censorship was not discussed. However, censorship and its effects became extremely apparent during my second job at an inpatient psychiatric hospital. Fortunately, during that time I enrolled in the master's program at Slippery Rock University which helped me grapple with the many layers of injustices in censorship and my own experiences.

Through intensives and classes at Slippery Rock, I began to awaken to my own harmful experiences as a woman and my tendency to compare it to others with varying marginalized identities. This comparison and binary thinking of, "someone has it worse," often led to minimizing or negating my experiences as I focused on others, which perpetuated the patriarchal expectation of caring for others at a personal cost. As a cis-woman in her late twenties, I had countless interactions where others have not taken me seriously, listened to me or believed me due to my gender. I believe this relates to censorship, as censorship in essence, is about whose voice is listened to, and the ways you adapt and change yourself and your self-expression to be heard or belong.

In my experience as a music therapist, identities and censorship became increasingly difficult to navigate as I became the only music therapist at my facility. While there are no formal written policies that regulate content or language in songs, it is part of the expectation and culture to omit certain narratives in music that include swear words, violence, and references to drugs and alcohol. This was decided without a music therapist in the discussion and decision and

is communicated verbally through veiled threats regarding my job, as a former music therapist was fired for use of unapproved songs. As a clinician it has been very difficult to inform clients we cannot listen to their music. As a person it is incredibly taxing to filter my identity and values for job security, while also asking clients to filter their experiences to fit a potentially oppressive power structure.

One poignant example of censorship's effects occurred in an adult group where I declined playing a middle-aged man's song due to content and language. The song included themes on substance use and recovery, however featured detailed and graphic depictions of drugs with related language. I remember feeling physically sick when I read the lyrics ahead of time because I knew the song was so important in this person's experiences, however, I knew I could not play the song as there would be potential for disciplinary action, judgement and reprisal from coworkers. When I gave my rehearsed speech and rationale explaining why the song could not be played, he looked at me and said, "it's like you're not even letting me be here."

In writing and developing this thesis I have reflected on music throughout my life and why this topic is so important to me. As a lifelong musician I was part of many wind ensembles and choirs. These ensembles and people became a community to me, one where my voice mattered and I was heard as an individual who contributed to the group. To me there are few things more sacred than giving voice to your inner experience through music and being heard and supported. Music has always been a space where I can be unapologetically myself and express myself.

However, when conducting and transcribing the interviews, it became apparent that I may silence or censor myself in the therapy and music space. I am acutely aware of asking clients to adapt and change their narratives through music, however I had discounted the toll and impact it

has on me as a clinician and person. This will be something I continue to reflect on as this is very much a part of my history and lived experience in my family system and as a woman. I believe the music space and relationships forged in music can serve as an encouragement to others to express and live as their authentic selves; but I must be willing to do so myself.

It is my hope that this thesis and interviews will facilitate a broader discussion within the music therapy community. Censorship is a complex issue with many layers such as relationships with coworkers, and job security in addition to sociopolitical factors in and outside of the music space. Censorship begs the question of who is permitted to be wholly themselves in the therapy space, who must adapt and censor themselves, and who is excluded in the music space.

Positioning

I am a white, cis-woman that is nondisabled and from a middle class family. I am the first in my immediate family to receive a collegiate education and grew up in a family system that values hard work, dedication and relationships. These values are core elements of my identity and contribute to my personal experiences with censorship in my work setting. Throughout this process I have sought to maintain and validate my own experiences while simultaneously engaging in discussions with participants in an objective manner. There were moments in the data collection process where I was acutely aware of my social positioning, and differences I am afforded as a white therapist that others may not experience. There were also moments of support and unity where it felt as though I was hearing my experiences from someone else. Engaging in semi-structured interviews helped me remain objective at times as I focused on the pre-written questions, but also gave me freedom to explore other topics that emerged. Throughout this process I engaged in weekly supervision with my cohort, sought additional counsel from members of my thesis committee and journaled on my emotional experiences.

Literature Review

Despite the significant history of censorship in the United States, few studies examine the effects of censorship in a therapeutic context. Censorship refers to an entity in power altering or omitting language and content based upon perceived consequences and hopes of maintaining normalcy for dominant values and power. The impact of censorship is evident throughout history as certain perspectives and values were more accessible to the public, while other narratives were difficult to access or even banned. These perspectives and values communicated attitudes of individuals in power and dominant identity groups which came to fruition through accessibility, and societal attitudes toward diverse narratives in music.

History of Censorship

In the United States, the colonialist value of freedom of speech was reflected in the first amendment of the constitution (Chastagner, 2007). However, freedom of speech has not always provided protection for artistic works and media. This is evident throughout American music history, beginning as early as the Civil War and continuing to modern day. Following the Civil War, the government banned pro-southern songs out of fear of revolution and pro-southern feelings (Nuzum, 2001). The government justified this to maintain peace and the newfound collective identity of the United States. However, the outright ban of pro-southern songs removed individual independence for the purported collective good and identity. This collective identity was forged through banning of such music and fostered a sense of public spirit, as individuals were united through music that was presented and approved by individuals in power. As Chastagner (2007) noted:

> Censoring implies the existence of a 'public spirit'. There seems to be a threshold beyond which liberty must give way to control in order to protect the foundations of a country's

> collective identity. A fictitious, homogeneous community made up of 'average people' is the necessary pre-requisite for the establishment of any restriction on individual freedom. (p. 4)

Given the presence of a 'public spirit,' censorship may create divisions between individuals that comply with group expectations and norms and those that do not. For example, the outright ban of pro-southern music may have separated people that held fast to their southern music and values, compared to individuals that followed the set precedent from the government. While the alleged goal of the ban was unification and a sense of public spirit, the ban removed individual's opportunities for self-expression and autonomy of choice in music.

Another notable instance of censorship was the public response and accessibility to jazz and blues music in the early and mid-twentieth century. Black music was strongly influenced by unspoken expectations and censorship from white audiences. These one-dimensional expectations were depicted in artwork surrounding the performers, and featured instruments, such as the tom tom drum, which alluded to primitive stereotypes and racist tropes, and ultimately resulted in early jazz being labeled as "jungle music". While Black musicians were permitted to play in some venues, it was done in a reductionistic and voyeuristic manner for the white gaze, perpetuating racist and nationalistic beliefs for those in the dominant racial group. Brown and Volgsten (2006) boldly asserted that "censorship is often rooted in political and religious ideologies underlying such divergent practices such as nationalism, racism, traditionalism, and sexism" (p. 239). Sloan (2016) goes further and describes the Cotton Club, "as a whites-only venue in the heart of Harlem that capitalized on exoticizing and stereotyping black culture, predicated on the 'slumming' economy of Harlem nightlife, the Cotton Club seems to negate a heroic narrative of American jazz" (p. 1). It is important to note the complexity and

critical thinking required for early jazz, as it was heavily dictated by dominant values and beliefs. However, it also provided opportunities for Black performers to collaborate, perform, and to ultimately "develop many fine black performers," which "gave them a major leg up to national recognition" (Hennessy, 1994, p. 100). This period of music demonstrates the complexities and nuance of censorship in music which continued throughout the century to the present day.

Censorship continued into the 1950s as technology advanced. Music giants Billboard and Variety, "launched a crusade against 'leerics' in Rhythm and Blues songs, which led to the banning of many R&B records by jukebox operators and radio stations disk jockeys" (Chastagner, 2007, p. 10). This resulted in many states and religious institutions lobbying radio stations to comply and discontinue playing rhythm and blues songs, and later rock and roll, which disproportionately censored Black artists. In addition to lobbying and social pressure, the government also exerted control and power through the Federal Communications Commission (FCC). The FCC was founded in 1934 to monitor audio communication through radio and was able to "suspend the licenses of providers who were broadcasting obscene or profane language" (Pearson, n.p). However, the criteria for obscenity was ambiguous in nature, and often affected individuals from minoritized groups.

In the 1950s, censorship became a means of 'protection' for individuals from the dominant group (white people), to spare their feelings by minimizing discomfort and maintaining a sense of 'decency.' Chastagner (2007) states:

> African American genres frightened because they expressed every aspect of human nature, including sexuality; the rampant discrimination against African-American culture was thus made legitimate and respectable since censoring these musics was presented as a crusade for decency. While black music had been directed at the black

> market, no one had really objected; it is only when the white youth began to be attracted that the attacks really began (p. 9).

As young white interest in Black music increased, there was more opposition from individuals in power due to inaccurate stereotypes. The division in music and media became more severe over time due to an increase in technology, unchecked power, and white institutional power, which resulted in racially motivated censorship.

As technology became more advanced and commonplace, many families began to own televisions in addition to radios and record players. This presented additional material for corporations to regulate and consumers to evaluate as they received media and news. Television shows and music specials became a staple, with shows such as the Ed Sullivan show becoming a fast favorite. In a 2012 Ted Talk, Belcik discussed the cultural importance of the Ed Sullivan show, particularly as a means of evaluating new musical artists and contemporary values. Furthermore, the Ed Sullivan show represented traditional Christian values of conservatism and chastity. This was evident during an infamous episode when Elvis Presley was recorded from the waist and above due to parents' concerns about his "sexualized" dancing (p. 2). Elvis drew heavily on Black music and dance traditions and thus concerns about his dancing were tied into racist ideologies. Volgsten and Brown (2006) asserted:

> Cultural artifacts carry with them the power to influence the minds and motivations of the masses, and with it the power to divert people from an awareness of and compliance with the normative behaviors of a society, as dictated by political and religious ideologies (p. 240).

Television and radio executives were the ultimate barometer and final decision-makers in determining accessibility of certain media to everyday consumers.

The impact and emphasis of Christian and 'traditional' (read white middle-class) values was apparent in the 1950s and continued in an opposition to rock and roll music. This later resulted in the development of the Parental Music Resource Center (PMRC) (Chastagner, 2007). Following the election and inauguration of President Ronald Reagan, the faction of the "Christian right" voiced their opinions and received attention, as members of the PMRC were white, wealthy, and conservative (Belcik, 2012, p. 3).

Given the amplified voices of the Christian right faction, the PMRC was created in May 1985 with the goal of informing parents about the perceived immoral content of rock records. Its board of directors consisted of 17 "Washington Wives", women married to senators, congressmen and Cabinet officials (Chastagner, 2006). These influential women and partners held power, as they wrote articles and engaged in interviews arguing the evils of music which discuss sex, violence, and drug usage and lobbied with radio stations to censor this music. The culmination of the PMRC's efforts resulted in a court trial to explore the effects of music and mass media on youth. The PMRC hoped to introduce measures to censor recorded music, live music at concerts, in addition to visual components of art. Nuzum (2001) stated that the aim of the PMRC trial was to provide lyrics on albums, assess content of performances and develop a community to lobby broadcasters to play approved content (p. 22). Many notable musicians testified against the PMRC, citing the threat of their first amendment right and free expression in music. Ultimately, the Audio Home Recording Act passed in 1992 which resulted in "a warning label on all relevant new releases, warning against so-called explicit lyrics referring to sex, violence, substance abuse, and containing swearing" (Nielsen & Krogh, 2017, p. 346). Negut and Sarbescu (2013) explored the impact of this trial and its results, stating, "The pattern of labeling rock and hip-hop music as problem music may, in fact, create stereotypes of those music genres,

making at least the lyrics of the music look more problematic and deviant than they actually are" (p. 11). As such, this extreme labeling creates separation between people and may advance and perpetuate dominant society's narrow and inaccurate understanding of marginalized individuals and their experiences. Schneider (2011) notes the impact of dominant agendas and perspectives, stating, "The condemnation of marginalized groups and their cultural activities is reflexive of the dominant group's membership and social reality" (p. 37). The social reality of people in power is reflected in the perceived need to remain separate and distant from others that do not align with their values or identities. This fear is made evident in the founding of the PMRC, their lobbying efforts and subsequent censorship of music by individuals in power.

Censorship and a lack of accessibility to diverse music limits peoples' ability to learn about others' experiences and grow in understanding. It also maintains the status quo as marginalized peoples' experiences are censored by dominant political powers. This ensures marginalized peoples' identities remain subjugated, which may comfort or serve individuals with privilege. As a result, societal roles are maintained and stereotypes continue unchallenged. Reyna, Brandt, and Viki (2009) conducted a survey that examined the effects of prejudice and stereotypes, finding that white respondents' associations with rap music included stereotypes that Black people are "responsible for negative life outcomes, and have lower levels of innate ability..." (p. 368). These unchecked stereotypes continue to impact marginalized individuals by reducing or eliminating their experiences, and leaving privileged individuals with unexamined biases.

The history and impact of censorship in American music is well documented by a broad range of professionals, such as musicologists, historians, psychologists, and sociologists, amongst others. The myriad fields exploring this topic demonstrates the breadth and reach of

censorship and illustrates the effect of censorship on everyday people and relationships. It is imperative to understand the history, political nature, and nuance of censorship and how it may differently impact others based upon their lived experience and cultural identities.

Music therapy and Censorship

The field of music therapy has limited research on censorship and its clinical implications. In music therapy, music serves as one third of the therapeutic relationship between the therapist and the participant (Bruscia, 2014). Music provides a wide range of options for self-expression as participants carefully select non-verbal musical accompaniment to express themselves, in addition to curating and sequencing words to authentically capture their lived experiences through their lyrics. Within music therapy contexts, censorship may occur in songwriting activities, singing, song discussion, improvised music, or shared recorded music. Due to the wide range of censorship in music therapy, this researcher selected song discussion as the focus of this study, as it presents the most apparent form of censorship through lyrics and song selections. Song discussions can be loosely described as a clinician-facilitated conversation on elements in the song, such as instrumentation, tempo, meter and rhythmic elements, melodic and tonal elements, volume, as well as lyrical qualities such as characters, plot, and word choice.

While there is a paucity of research on censorship in music therapy, there are numerous articles and textbooks that discuss the functionality of music and song discussion (Dvorak, 2017; Silverman, 2019) or offer guidance on procedures for the therapist (Gardstrom & Hiller, 2010). Additionally, there are many studies that explore music as a means of self-expression and an extension of identity (Epp, 2020; Peters, 2020; Viega, 2012). This is vital to consider, as censorship in music may be understood as altering or omitting personal narratives in language and content. Of note though, is Joplin and Dvorak's (2017) survey in which they asked music

therapists working in mental health whether they actively censor lyrics and content in sessions and asked questions regarding their experiences with censorship. They found that music therapists most frequently censor music through omitting songs altogether or playing the "radio" edits of recorded songs. Furthermore, they noted that many music therapists engage in censorship through their decision making when determining what songs to bring to a session and how to visually present it on a lyric sheet, whether through edited words, symbols or blanks. Additionally, censorship impacted songs that clients requested and affected live music making and singing. This was apparent as music therapists faced the choice to honor and sing the original lyrics, or to censor lyrics through omission or lyric substitution. Joplin and Dvorak found censorship is executed through edited lyric sheets, the music that music therapists select, recorded songs requested by clients, and vocally improvised songs. While Joplin and Dvorak's survey offers insight into censorship practices in mental health, there are few studies in music therapy that take into account the material censored, clinical rationales for censorship, and who it impacts as a result.

Censorship can occur in music therapy through adaptations in song discussions. This is apparent as some songs may be played using the "radio" edit lyric sheets and may have symbols to cipher words. Some songs may never be brought into a session due to content or lyrics, thus creating a secondary layer to censorship and accessibility. These edits and censors may be contrary to the objectives of song discussion, which aim to address relevant themes such as, "change, support, addiction and abuse, problem identification, symptoms, coping skills, goal setting, hope, positive thinking, acceptance, self-awareness, anger, feelings, self-esteem, and social skills" (Dvorak, 2017, p. 191). Furthermore, Gardstrom and Hiller (2010) describe the optimal benefits of song discussion as, "improved self-awareness, release of emotions,

development of healthy interpersonal relationships, healing of emotional trauma, and discovery of greater meaning and fulfillment of life" (p. 148). Since music can serve as a means of processing and reflecting on life, sharing music to reflect peoples' experiences can feel vulnerable to share as it is an audible and external representation of the internal experience and self. Engaging with censored material may lead to a person feeling that their experiences are unpalatable to the therapist, inhibit participants' abilities to openly and candidly discuss their experiences, inhibit connection to others who have had similar experiences, and can lead to a sense of rejection. Despite potential consequences of censored music, Joplin and Dvorak's (2017) study demonstrated censorship is a common practice in music therapy across mental health settings.

Rationale for Censorship

Given the language and content presented in song discussion, there may be instances where participants feel uncomfortable, or become emotionally dysregulated despite the potential benefits of the experience. Joplin and Dvorak (2017) listed rationales for censorship as concerns for other group members' responses, the possible negative impact on the therapeutic relationship, that lyrics may incite self-esteem issues, or that lyrics may incite emotional distress. Thus, censorship in these contexts may involve the therapist making decisions for group members as a means of shielding participants from potential distress. Emotional distress or dysregulation may result in urges or acts of self-harm or thoughts of killing oneself, which can be prevalent in mental health settings. The potential link between rock and roll, metal, and hip-hop music and self-injurious thoughts was a large component of the PMRC's campaign in the 1980s. Tipper Gore, a founding member of the organization often spoke broadly and in generalizations about

white teenage males and an alleged increase in suicide (Chastagner, 2007, p. 7). Chastagner (2007) states:

> [Tipper Gore] made an (often erroneous) assertion about youth culture such as 'young white males are also the primary audience for heavy metal', and leaving the reader to draw his own conclusion: 'what happens when a confused, depressed adolescent picks up the album...? (p. 7).

Music and Harm

The notion that music can be harmful is not frequently discussed within the field of music therapy (Murakami, 2021) or other therapeutic disciplines (Carpenter, 2017; North & Hargreaves, 2006; Scherzinger, 2007). However, harm is prevalent in the justification of current censorship practices by music therapists in certain work environments and cross-disciplinary research and ethics. In a study on "Problem music and self-harming," North and Hargreaves (2006) labeled "problem" music as "hard-rock, hip-hop and punk" (p. 582). The questionnaire revealed the complexity of the topic, acknowledging additional components such as "delinquency, conservatism and self-esteem" in connection to self-harm and suicide (p. 584). North and Hargreaves' (2006) study demonstrated that participants' "liking of problem music is also related to delinquency and conservatism," (p. 586), however, they found, "no evidence that participants began listening to their favorite music *before* they began to consider self-harming, and nor was this the potential effect associated more closely with fans of problem music" (p. 588). As such, there is no evidence for the idea that listening to this music was the direct cause of harm or even increased self-injurious behaviors in listeners.

Central to any helping profession is nonmaleficence, or the notion of "doing no

harm" to clients, and ensuring the client's right to safety. The American Music Therapy Association's (AMTA) code of ethics was developed to govern and guide music therapists, and was recently updated in 2018. Relative to the code of ethics, the AMTA recently outlined core values such as: "(1) respecting the dignity and rights of all, (2) acting with compassion, (3) being accountable, (4) demonstrating integrity and veracity, and (5) striving for excellence". These values and recent music therapy research on harm (Murukami, 2021) emphasize the need for self-reflection for therapists, stressing the importance of evaluating current practices and the possibility of enacting harm through their actions or inactions. This is relevant to censorship as it is a complex issue that requires critical thinking and constant observational skills during sessions to monitor participants' responses. Decisions around censorship may feel unclear to clinicians as each encounter is situation specific; participants may experience harm from either hearing an uncensored song, or experience harm as a result of censure of their music.

While North and Hargreaves (2006) acknowledged the potential physical harm associated with music, Murakami (2021) outlines possible psychological harm from music, including "emotional dysregulation, mental rumination, feelings of danger, a decrease in a client's self-efficacy, maladaptive perceptions of reality, or the triggering of symptoms associated with a mental health diagnosis" (n.p.). Murakami (2021) acknowledged the breadth of the topic of harm, stressing the need for a music therapy and harm (MTHM) model which includes the client, music, therapist, and the relationship between the three. In this model, Murakami (2021) identified six situations in which clients may experience harm: 1) the music presented, 2) the music therapist, 3) the therapeutic application of music, 4) the therapeutic relationship, 5) client-specific music associations, and 6) ecological

factors. However, Murakami postulates "these same factors are theorized to act as protective elements that allow music therapists to remediate instances of harm and promote client resilience in the face of negative music therapy experiences" (n.p.). Given the complexity and uniqueness of each clinical situation and the power imbalances in the therapy relationship, it is imperative for the clinician to be reflexive and cognizant of participant responses to music therapy experiences and make adjustments accordingly.

Mandate from management to censor

In addition to music therapists experiencing fear that the therapeutic relationship would change as a result of hearing uncensored songs, Joplin and Dvorak (2017) found many participants also identified "facility or unit required" policies regulating language and song content. It is common for a therapists' manager or executive board to regulate language and references to drugs, alcohol, sex, violence, and swearing. These implicit or explicit messages from individuals in positions of power may shape group norms for the therapy group such as how to express yourself, who is represented, who is excluded, and so on. In addition, they may present additional challenges for the therapist to navigate.

Lucas (2013), described the result of dominant power in censorship, stating, "Most creative arts workshops in prisons tread lightly on the subjects of abuse or inequality during incarceration; prison administrators tend to censor any material that critiques the prison industrial complex or those who work for it" (p. 145). Censorship in this capacity serves as a means of protecting systems in power from critical questions or repercussions, thus eliminating the possibility for marginalized individuals to critique, authentically express themselves, and comment on their realities. For example, Lucas (2013) recalled the impact of a prison guard completing rounds and the effect on the music group and group writing:

> The guard did not intervene to censor the song, but the apprehension caused by his or her appearance in the workshop during this rare moment of social and structural critique highlighted the shift in the content of the women's writing (p. 156).

The power differences between management, many of whom are members of dominant sociocultural groups, and those who have marginalized identities is stark, often negatively influencing self-expression simply by the presence of people in power. As such, ecological factors and power imbalances may impede an individual's capacity for self-expression due to institutional policies or regulations, in addition to self-imposed censoring by music therapists out of fear of adverse consequences. Censorship from management is also relevant to song discussion across music therapy settings, influencing material that may be brought into a session and songs that participants may select and share.

Impact of censorship on the client

The impact of music as a means of self-expression is well documented (Bruscia, 2014; Epp, 2020) and remains an integral part of the therapeutic process. Song discussions offer a means of understanding self in the context of one's life and in the context of relationships with others through externalizing internal thoughts and experiences and processing relevant themes with others. Given the prevalence of censoring or omitting certain songs during song discussions (Joplin & Dvorak, 2017), participants may lose opportunities for self-reflection, to be challenged by others or to connect to others with similar experiences. Epp (2020) writes on functions of music, particularly as an autonomous voice and extension of self:

> We feel personally expressive because we are actively locating ourselves in that which is outside ourselves. We are not manifesting an essential identity through a musical

> structure; we are at once revealing and creating the truth of our social existence, finding and asserting our *freedom within*, as Goehr would say (p. 13).

By engaging in non-limited music making and uncensored self-expression, adults may experience meaningful ways to connect to themselves and others, in addition to expressing a range of emotions such as pain, anger and aggression without fear of judgment. Engaging in authentic expression of these emotions may culminate in a louder volume or an unlimited range of words and lyrics, which provides unique opportunities for participants to fully express their emotions in an unfiltered and safe manner. When engaging in improvisation or song writing experiences, Solli and Rolvsjord (2013) stated, "Using swearing and rude words in song-lyrics and raps, and hitting drums and playing on distorted guitars, were given as examples of ways of getting in contact with and expressing these emotions" (p. 76). Engaging in authentic music making or listening can be liberating for participants and provide unique opportunities for expression to be heard and validated and receive support from peers.

In addition to building peer to peer relationships, Short (2020) described using uncensored music in music therapy as a means of building therapeutic rapport. They state:

> At the beginning of a relationship, I want the person to feel accepted and that their expression is acceptable to me, even if it's problematic in making me feel uncomfortable and then once the therapy relationship is established and they trust me . . . then when stuff is problematic, when there's a b**tch and a mother f**ker, I can challenge them on it. (p. 4)

However, given censorship practices, it is possible participants may be denied experiences to express their emotions fully or to build relationships with others and themselves. Short (2020) goes further and states:

> The whole point is they have to be able to recognize their own emotions and work with them rather than acting out their emotions impulsively and harming someone. Nothing so far as I'm concerned, would have happened that was therapeutic if I'd put constraints on which words they used within the Rap (p. 13).

Authentic and uncensored music provides invaluable opportunities for adults to engage in unfiltered self-expression that accurately captures their experiences, in addition to safely expressing their emotions.

These constraints also relate to the representation of musicians of certain cultures that the therapist presents or participants share. Given mandated institutional censorship practices, therapists may be limited in songs and styles of music they may include. These censorship practices may send messages to participants regarding what is acceptable in the group, how to express oneself, and who is welcome in the group. As such, censorship practices may aid in creating a schema of insiders and outsiders through representation in presented or shared music. This schema is evident in what Chastagner describes as a, "great national family," which is composed of like minded individuals with similar values or the same identities. Chastagner (2017) goes further and states, "Any type of censorship is in fact a form of exclusion, the sacrificial expulsion of everything that interferes with the smooth working of the great national family" (p. 5). For individuals in the "great national family," (read white, conservative Christian), discomfort, accountability, and radical truth may be construed as threatening, and thus lead to exclusion, and continued normalcy for members of the "great national family" through unchallenged stereotypes. This affects everyone involved in music therapy, as participants are presented with two dimensional characters that maintain comfort for members of dominant groups through known stereotypes. However, this is a detriment to all group members as

individuals from minoritized groups lose opportunities to be wholly themselves, and members of dominant groups lose opportunities to challenge preconceived notions or stereotypes, to learn from others and grow as individuals to become more just and whole versions of themselves.

Similar to members of the PMRC and radio executives, music therapists, and those with power in the work environment, may become gatekeepers of what is permitted and deemed appropriate for a music therapy session. Schneider (2011) asserted that censorship affects not only representation, but the creation of continued negative perceptions of music, which over a period of prolonged time, become anchored in collective memory and consciousness. Negut and Sarbescu (2009) provided examples of unchallenged stereotypes and negative perception of music styles, stating:

> As a consequence, we propose that in the case of rock and hip-hop music, cognitive resources are insufficient, and because cognitive capacity is diminished, stereotypes may activate easily and individuals are more prone to evaluate these music genres according to stereotype consistent information (p. 4).

Due to the unquestioned stereotypes and lack of varied music experiences, individuals with marginalized identities are reduced and held to a performative identity that aligns with dominant beliefs. For instance, if a person was told that rap is too sexual or violent throughout their life, they may have limited exposure to this music due to biases about the culture, people, and music. If this person is in music therapy and not exposed to rap music, these stereotypes may remain unchanged and may advance the belief that rap music or hip hop culture is not suitable for a public space. This perspective was apparent in Rentfrow and Gosling's (2007) survey where more than half the participants were white. Rentfrow and Gosling's (2007) survey of college students found that participants associated rap music fans with alcohol and marijuana use and

high athleticism (Black stereotypes). Reyna et al. (2009) reflected similar results in their survey, finding that white participants felt that rap fans "placed a higher value on personal respect and recognition and had little regard for values of peace, security, civility, and intellect" (p. 362). As such, clinicians must navigate stereotypes and misconceptions surrounding styles of music due to participants' schemas and past experiences as a result of censorship.

When navigating censorship and stereotypes, it is important to reflect on the demographics of music therapists. A 2018 work-force analysis revealed 88.4% of music therapists are "white, caucasian or European." As a predominantly white profession, music therapists must recognize ways they perpetuate and advance values of dominant ideology onto others and the effect of such ideology on their clients, many of whom are members of marginalized groups. Norris (2020) asserted that music therapists may "conform Black client communities, their aesthetic being, cultural memory, musicking practices, language and communication styles, meaning-making processes, stress appraisals, coping mechanisms, cultural existence--to dominant groups and norms" (n.p.). This reductive and oppressive response is evident throughout settings in music therapy, ranging from forensic settings to mental health treatment facilities.

Similarly, Lucas (2013) reflected on a final performance by incarcerated women and the stereotypical and limiting expectations of the audience, stating, "Prisoners have authority over little more than their own actions and emotions, and audiences--including Reitman [a therapist]--expect them to tell the truth in a way that performatively feels like the sort of narrative they expect a prisoner to be telling" (p. 142). This may occur as audience members may be anticipating a storyline that depicts experiences at "rock bottom," and a redemptive arc.

Furthermore, individuals with marginalized identities are often viewed and confined by dominant beliefs from larger systems in power. Leonard (2020) observed:

> Ideas and discourses related to treatment planning, clinical goals, thoughts that center on appropriate language and censorship, viewing clients through a primary lens of behavior/behavioral outcomes, and a general worldview of the music therapist as the expert or as the supplier of knowledge may be reductive, harmful, and support the white gaze with Black clients. (p. 109)

Conforming Black experiences to dominant groups may occur through censoring or omitting songs due to a therapist's rationale or policies in a work environment. In addition, a lack of self-reflection for the therapist's presented music may cause great harm to participants, particularly individuals with marginalized identities as the music may perpetuate stereotypes, ignore their wholeness, or conform their experience to dominant ideology. Furthermore, members of dominant identity groups that have negative beliefs about others from minoritized groups are left unchallenged.

Impact of censorship on the therapist

There are many implications for participants that experience censorship; however, there also many implications for the therapist. There has been minimal discussion of this in the literature. If a therapist engages in censoring lyrics and content of songs, there may be fewer opportunities for authentic self-expression for all participants, in addition to reduced potential for connection and validation between group members and the therapist. Additionally, the therapist may experience cognitive dissonance regarding censorship, which may increase likelihood for burnout and difficult interpersonal relationships. For example, a music therapist may struggle between honoring a participant's lived experience by playing a song that mirrors their

experience, while knowing that playing the song may cause harm to other participants or could lead to repercussions at their place of work. Moving forward, to honor the therapeutic relationship and the therapeutic process, it is imperative for music therapists to acknowledge our social location as well as responsibility and roles in our work systems when it comes to the issue of music censorship. Additionally, therapists need to consciously work to amplify voices and experiences of individuals with marginalized identities in a system that may consciously and unconsciously oppress them. This requires the music therapist to introduce a broader range of presented music, in addition to advocating to management for clients to be able to engage with music that is congruent with their experiences.

Contrary to its lengthy history, research or protocol on censorship in music therapy is lacking. There are many historical articles in other disciplines that provide insight into the history of censorship, its rationale, advancement of dominant agendas and maintenance of normalcy and comfort. While there are many articles on the function of song-discussion (Silverman, 2019; Gardstrom & Hiller, 2010), or music as a means of self-expression (Epp, 2020), there are limited articles that acknowledge censorship in this practice. While there are many articles from different disciplines such as musicology, social work, or sociology, music therapy lacks research that explores the impact of censorship on participants and therapists. It is also important to note that the few existing articles on the impact of censorship in music therapy focus on the music and clients, omitting the experience of the therapist. As such, the purpose of this thesis is to evaluate censorship regulations and practices in song discussion in the mental health setting and its effects on therapists. Specifically, this research examines the effects of censorship on therapists' experiences of clinical efficacy, authenticity, and relationships to co-workers and clients.

Theoretical Framework and Research Methodology

Due to the nature of the research question, this study adopted an interpretative phenomenological approach (IPA). IPA is rooted in phenomenological philosophy, which is "a reflective study of a prereflective or lived experience" (Adams & van Manen, 2008, p. 614). Within music therapy research and literature, Wheeler (2016) writes phenomenological studies "seek understanding of lived experiences and the meanings that emerge as individuals experience phenomena in their everyday lives--in the lifeworld" (p. 212). These individual experiences, cultural identities and unique life histories comprise peoples' lifeworlds. A lifeworld can be understood as "the context wherein an individual has meaning as a person as the result of enculturation and wherein meanings are made through perceptions, cognition, and language surrounding phenomena and experiences" (Adams & van Manen, 2008, p. 614). As such, a phenomenological philosophy was imperative to this study to recognize the uniqueness of each person's experience, their understanding of a situation, and how that meaning impacts and interacts with their lived experience.

Adam and van Manen (2008) further state phenomenological approaches are "more sensitive to subjective and intersubjective roots of meaning, to the complexity of relations between language and experience, to the cultural and gendered contexts of interpretive meaning, and to the textual dimensions of phenomenological writing and reflection" (p. 616). For this reason, a phenomenological approach, specifically IPA, was chosen for this study to honor the individuality and cultural aspects of each participant's lived experience with censorship in the workplace. Smith and Osborn (2015) write:

> IPA is phenomenological in that it involves detailed examination of the participant's lived experience; it attempts to explore personal experience and is concerned with an

> individual's personal perception or account of an object or event, as opposed to an attempt to produce an objective statement of the object or event itself (p. 25).

As such, IPA is idiographic in nature as the interest is in the detailed examination of particular cases and understanding how particular people have experienced events.

Procedure

To ensure a wide range of responses across regions, work settings, and lived experiences, I posted a call for research participants on several social media pages (see Appendix A). In addition, several participants were gathered through purposive sampling to ensure a diverse sampling due to the innate cultural components of censorship. To engage in this study, participants met the criteria of working in a mental health setting for at least a year, spoke English, experienced censorship practices, or worked in a setting that values censorship.

Upon initial interest, potential candidates completed a Google survey where they included demographic information such as setting of work, years certified as a music therapist, personal pronouns, race, and gender identity. The Google form allowed short answer responses to self identify and ensure authenticity and inclusion. As per IRB approval, in collaboration with two thesis committee members, I selected seven potential participants to interview based upon demographic information to ensure as diverse a group as possible (see Table 1). These individuals were emailed the consent form (see Appendix C), then after answering any questions participants had regarding the research, I scheduled interviews per the seven participants' schedules.

Participant Demographics:

Table 1

Gender identity
"Queer" (n=1)
"Femme" (n=1)
"Nonbinary" (n=1)
"Cis woman" (n=1)
"Female" (n=2)
"Male" (n=1)
Race
"White" (n=2)
"Black" (n=3)
"White Middle-eastern" (n=1)
"TBD" (n=1)
Work setting
Inpatient (n=3)
"Correctional facility" (n=1)
Partial hosp. (n=2)
Drug & alcohol (n=1)
"Residential treatment facility" (n=1)
Years of practice
1-5 (n=2)

5-10 (n=3)

10+ (n=2)

Interviews

Semi-structured interviews were utilized to give a rich and detailed narrative of participants' experiences. This was selected over a qualitative survey due to the flexibility and the potential for a deeper exploration for the researcher and participants. Semi-structured interviews differ compared to structured interviews as the latter value control over flexibility and uniformity over exploration, while semi-structured interviews provide control, reliability, and speed (Smith & Osborn, 2015, p. 30). Furthermore, semi-structured interviews permit additional questions or comments as IPA focuses on emerging themes through the dialogue between the researcher and participant. IPA is considered a two-stage interpretation process where the researcher strives to understand the participants' lived experience, as the participant explores their responses to the phenomenon (Smith & Osborn, 2015). As such, it is helpful for the researcher to be able to ask additional questions to ensure accuracy in the participants' narrative as relevant themes emerge.

Data Collection Procedures

Upon receiving completed consent forms, I scheduled one semi-structured interview per participant. The length of interviews ranged in length from twenty to seventy minutes based upon participants' experiences and openness. In an effort to ensure confidentiality and anonymity, each participant selected a pseudonym to use in the transcript and subsequent research. All seven participants were asked the same seven prepared questions (see Appendix D) and were asked follow up questions as appropriate due to the structure of the interview design. Each interview was recorded and uploaded to the Zoom cloud, and then downloaded and

transcribed using *Transcribe.wreally.* After each interview was downloaded and transcribed, it was promptly deleted from the Zoom cloud and *Transcribe.wreally* database. Following the completed transcriptions from *Transcribe.wreally,* this co-researcher listened and corrected the transcriptions for accuracy.

Data Analysis and Interpretation Procedures

Interpretative phenomenological analysis focuses on idiography (a process of discovery of individual experience) over nomothetic research (generalized statements on behavioral patterns). Due to the individualized experience, I read each interview separately at least three times and coded for themes. Analysis of each interview included the therapist's experience, their self-concept, interpersonal relationships between co-workers and clients, their relationship with music, in addition to themes unique to each interview. Throughout the analysis, I engaged in reflexivity and reflected on my own experiences with censorship and raw emotional responses to the content by maintaining a separate journal for my responses. Additionally, I engaged in discussion with members of the thesis committee to reduce the potential for bias or my own projection of experiences.

Each interview was read separately, coded by relevant thematic content, and then compared for similarities and differences across other interviews. Data was further coded by selecting meaningful quotes and themes while noting the validity of the individual experience compared to other participants. The raw data was then uploaded into Atlas.ti, a software program specific to qualitative data analysis and coded accordingly. Several themes were condensed, additional themes and insights were added and self-reflection occurred in a weekly supervision meeting with other students developing their theses. After completing and reviewing analyses

from the thesis committee, I emailed each participant a copy of the transcript and their essence to review and edit to best fit their experience.

Validity

Crewell (2018) states validity in qualitative studies is "an attempt to assess the 'accuracy' of the findings as best described by the researcher, the participants and the readers (or reviewers)" (p. 259). To ensure validity, this study utilized member checking through correspondence with participants after the interview. Participants were provided a copy of their interview transcript and analysis, to edit or correct to best represent their experience. Korstjens and Moser (2017) highlight member checking as a valuable strategy to ensure credibility, while reflexivity is a key criterion to ensure trustworthiness of qualitative studies. I utilized several reflexive strategies throughout this process such as journaling about my own experiences with censorship, emotions and responses to the interviews, in addition to engaging in dialogue with my thesis committee.

Ethical Considerations

Given the emphasis on the therapist's lived experiences and personal nature of this study, I engaged in discussions after each interview to provide opportunities to reflect and process emotions related to the questions and their personal experiences. Following the completion of the questions and interview, I stopped recording to create a space for participants and myself to process experiences from the interview and share my rationale and experiences that led to this topic of this research. After completing the questions and interview, participants were invited to email any further thoughts or experiences as they developed to ensure authentic narratives.

Findings

The purpose of this study was to evaluate censorship regulations and practices in song discussion in mental health and its effects on music therapists, such as perceived effects on clinical efficacy, authenticity, and relationships with co-workers and clients. Participants engaged in a semi-structured interview with relevant follow-up questions regarding their self-concept and relationships with others in a work environment that values censorship practices. Their responses addressed burnout and hypervigilance, strained relationships, and different perceptions amongst co-workers regarding the function of music therapy.

Five themes with nine sub-themes emerged through data analysis. The five core themes included 1) therapist conflicts, 2) fear, 3) inner responses in relation to music censorship, 4) types of censorship, and 5) the impact of other professionals on therapist decisions. The first three core themes feature at least four aspects that describe the individual experience of the music therapist in relation to their clients, co-workers, the work environment, and the institution. Responses highlighted the professional relationships and connections between various systems at therapists' work. Additionally, responses dictated the interdependence of the therapist, clients, co-workers, and institution, particularly the impact of censorship on therapists and clients.

Table 2 Themes and sub-themes

1. **Therapist conflicts**
    a. professional conflict
    b. therapist desire to be liked or viewed positively
    c. personal conflict and guilt
    d. therapist insecurity
    e. feeling pulled between relationships

2. **Fear**

   a. fear of consequences
   b. fear of harm
   c. fear of violence
   d. fear of loss of relationship

3. **Inner responses in relation to music censorship**
   a. emotional responses
   b. somatic responses
   c. psychological responses

4. **Types of censorship**
   a. Method of censorship
   b. Content of music censorship

5. **The impact of other professionals on therapist decisions**

This section describes and explores each theme and its corresponding subthemes. I provide narrative excerpts to illustrate the themes and subthemes. Narrative portions and quotes will be placed in quotation marks in the body of the text and italicized when given their own paragraph. To protect participants' identities and ensure confidentiality, each participant selected a pseudonym for the data and all other identifying information was de-identified. Overarching observations and implications of the data analysis will be explored in the discussion section.

Theme 1: Therapist Conflicts

There were several kinds of conflicts (tension in opposing values) for each participant. This was observed in five different ways, which are presented here as sub-themes: a) professional conflict, b) therapist desire to be liked or viewed positively, c) personal conflict and guilt, d) therapist insecurity, and e) feeling pulled between relationships.

Table 3

1. **Therapist conflicts**
   a. professional conflict
   b. therapist desire to be liked or viewed positively
   c. personal conflict and guilt

d. therapist insecurity
e. feeling pulled between relationships

Professional Conflict

This sub-theme was present in the interviews of six of the participants. Participants described tension related to their professional identity, which can be understood as a discrepancy between participants' understanding of music therapy and their role as a therapist compared to other professionals' perceptions of music therapy. Bloom described interacting with medical professionals in an elevator, stating:

> *"I think I'm interacting with the surgeon who thinks I'm exclusively a Kumbaya supplier. I can't tell you how many times people think 'what a fun job' and I'm like, 'oh, yes, I'm going to an extubation. I wouldn't call it fun at all, you know, but I will do what I need to to respect the dignity of this life that we hold in our hands. Thanks for asking.'"*

Participants described feeling misunderstood by colleagues which then contributes to a desire to demonstrate the efficacy of music therapy and their professional roles. Furthermore, colleagues' perceptions were often in opposition to the therapist's experiences in group music therapy, leading to disconnection from coworkers. Participants reported overt and covert messages within their workplace that invalidated music therapy.

The general misunderstanding of music therapy amongst colleagues caused several participants to evaluate their education and training on censorship. Participants felt underprepared from their training to navigate censorship issues with clients, as well as to advocate for clients within their workplace. They also considered how their clinical decisions could impact the future of music therapy at their work environments. Diana reflected on her job in the correctional setting and her fear for the future of music therapy if she did not comply with

her work protocol and culture by censoring music. She was worried that allowing music with explicit or violent lyrics could jeopardize future music therapists obtaining employment at that facility. She stated:

> *"I was very conscious of not only my own job there, but also that I'm representing music therapy and this environment and if I'm not careful about how I represent it then any other music therapist that tries to come in here, like, would they even get hired for one, and might have like an uphill battle in terms of re-educating."*

Therapist desire to be liked or viewed positively

This sub-theme emerged in the responses of all seven participants. Participants discussed this in terms of their role as a leader or expert, their desire to be experienced as a good person, and their responsibility to all participants. Across interviews, each participant described the role of the therapist as a leader/expert and explored nuances such as sharing power with participants while also ensuring safety. Alex reflected on their process of censoring and clinical decision making, stating:

> *"It does relate to how I see myself with various identities including my identities as a white person and so that can sort of open up things within the group to start thinking about that and then other times when I do censor some things, I see myself as somebody whose role is to keep the group safe, and you know, that could mean for people in the room, [and] that could mean broadly my sense of responsibility to a larger community, things like that."*

Alex and other participants demonstrated awareness of their social identities and power within the group settings and how this might be experienced in relation to censoring music. While this

awareness is crucial, white participants indicated they may compensate through performative or protective behaviors due to white guilt and saviorism.

In addition to showing clients they are culturally responsive, the participants discussed maintaining a positive image by focusing on what they can control while acknowledging external influences that limited their decision making. Stella commented that it was difficult for her personally, stating, *"I don't enjoy being the person who has to like crack the whip about it,"* when censoring participants. Furthermore, Stella and several other participants had scripts or disclaimers they told to group members, assuring them that systems of power in their work environment forced them to censor music and that it was not the therapist's own decision. Stella stated:

> *"I'm really up front with 'I don't necessarily want to restrict this from you. This isn't necessarily what I want to do as a therapist, and this is what the hospital stated, and the reasons are because some people are quickly activated by this and if that's you, I want to respect that and validate that, and you know there's a lot of different things that could trigger people and this is what we got to do.'"*

By placing responsibility on administration, participants avoided blame for their clinical decisions and maintained a positive view of themselves.

Personal conflict and guilt

Each participant acknowledged instances of personal conflict and guilt when experiencing censorship practices in their work environment. Participants reflected on personal discomfort when engaging in censorship practices which violated their personal values and relationship with music. Within this sub-theme there were four feelings that frequently emerged. These were feelings of guilt, discomfort, empathy, and shame. Personal conflict ranged from therapists'

personal experiences with the music, their discomfort and feelings of shame when censoring the music, to countertransference resulting from empathy for clients. The result of censoring or altering lyrical content appeared to bring guilt for several clinicians as they focused on their own experiences with music as a means of self-expression and coping with difficult emotions. Clarissa reflected on an instance where she was unable to play a song for a client due to language in the lyrics. She stated:

> *"Yeah, but kind of relating to having my own moments of when I also feel that heavy emotional response, wanting to break things, feeling unheard, feeling voiceless and then knowing that for myself that my coping mechanism is listening to music that is very emotional and meets me where I'm at because that's what helps me get through"*

Clarissa explored her own instances with personal music and countertransference, stating it is, *"this feeling that I'm censoring his life because he went through this, he is playing these songs and he's also expressed that this is his life. This is what is his normal"*. Stella recalled specific physiological sensations when enacting censorship practices that were contrary to her personal and musical values. Stella described it as:

> *"There's this kind of visceral gut, guilty, or shamey feeling of having to tab somebody's song and be like, I'm sorry this is not appropriate or whatever that means, and it yeah, it's a physically uncomfortable feeling that I have experienced in those moments."*

Vincent described a different type of discomfort as he went against his personal and musical values when censoring lyric sheets:

> *"There were some times if I was giving the lyrics to a kid, they wanted to hear lyrics to the song. As a clinician I felt fine, as a person who listens to music I was like I feel like a cornball right now. Am I really going to type this word ass, am I gonna type ash - am I*

really gonna do that right now? I feel so cheesy or just putting it in a in a bunch of asterisks or like b and a bunch of asterisks."

Vincent's discomfort differs from other participants as his experience with altering lyric sheets goes against his personal beliefs and experiences with music, leading to feeling like a "*cornball"* as he later described. Across all seven interviews, participants acknowledged feeling discomfort and worry when making clinical decisions about censoring. Participants such as Vincent acknowledged *personal* discomfort, while other therapists described *professional* discomfort, as they worried for potential repercussions from management, reprisal from co-workers or fear of harm to clients. Of note, many participants described somatic experiences that occurred when censoring, stating they experienced feeling, *"heavy," "pressure,"* or that it, *"brings a tear to my eye,"* demonstrating the physical and emotional impact on therapists.

Therapist insecurity

This sub-theme was present in the interviews of four of the participants. Therapist insecurity was described in the actions and motivations of both the clinician and their colleagues in their work environment. Their insecurities were observed in the ways that participants justified themselves, and provided rationales which reassured themselves and others. Participants also emphasized the belief that music therapy is valid in their descriptions when being questioned by co-workers which emphasizes the lack of understanding of music therapy in the work environment. This was most apparent in the ways that participants articulated the efficacy of music therapy, their positions, and clinical decision making skills to their coworkers. Alex reflected on an encounter with co-workers that had challenged their decisions on material and ability to explore difficult topics as a music therapist. They stated the coworkers inquired:

> "*…Is this okay to play [that song], or something like that, just inquiring about it with some concern, and usually I'll just say this is a space where I'm prepared to process what needs to be processed if it's appropriate, if it's in line with what the group needs, then usually I'm able to say yes, we're able to kind of take this on today. And this is a space where it might be different from in the community.*"

Alex defended their scope of practice, reassured co-workers of their therapeutic capability, and hinted at comparisons to community groups run by non-certified community musicians that co-workers may have compared to music therapy groups. Each participant acknowledged co-workers' questions about music therapy processes and readily shared rationale from their education and training, scope of practice, in addition to providing education on music therapy objectives. Stella compared her rationale to *"playing a game,"* by following management's instructions, and described her rationales stating:

> *"I've written little mini statements going into way more details than you should have to for three minutes long. But you know a page long justification of clinical value or whatever and I'm pretty good at using the right Buzzwords that will make it."*

Feeling pulled between relationships

All participants detailed conflicts balancing relationships with clients and co-workers. . Participants discussed difficulties in maintaining relationships with clients or co-workers, and burnout as a result of this discrepancy. Bloom described the need for compromise:

> *"inpatient Psych from my learning after having been there for the last 10 years is that it takes choosing battles wisely and acknowledging the surrender comes a lot [for] the clinician."*

Diana acknowledged the impact of her work environment in a forensic setting and the difficulty navigating relationships in harmful power structures. She reflected on the necessity to maintain relationships with officers and those in charge, stating:

> *"But at the same time I was concerned if the people that have to approve this music don't trust my judgment, then I might not be able to get anything, and so I definitely felt pressure to balance the needs of my patients and what was meaningful for them versus sort of meeting the needs of custody and understanding that power dynamic that existed there and where I fit into that."*

Other participants described the phenomenon of balancing their relationships with co-workers and those in charge, and their relationships with clients. Clinicians expressed uncomfortable emotions when censoring music because it was contrary to their personal values, and the experience of having to decide to please co-workers or clients added another layer of stress that leads to experiences of burnout. Diana reflected:

> *"Sometimes it wasn't that big of a concern to me because I was balancing all these other huge things, that it's like, you can't have this song that you want, versus pissing off officers and all the implications that comes with that, so I think that perspective was kind of always in my mind; my own preservation. And also the preservation of music therapy."*

Theme 2: Fears

The second core theme encompasses many fears the participants reported, these themes were divided into four sub-themes: a) fear of consequences, b) fear of harm, c) fear of violence, and d) fear of loss of relationship.

Table 4 Fears

2. Fear
a. fear of consequences

b. fear of harm
c. fear of violence
d. fear of loss of relationship

Fear of consequences

Participants consistently acknowledged a fear of consequences for themselves and clients. This sub-theme was mentioned across the seven interviews with anecdotal examples that included possible disciplinary actions, consequences for clients, and impairments to the clinicians' decision making and ability to do their job. The participants frequently focused on issues of control, as therapists tried to adapt to a work environment of fear and anxiety by over responding and anticipating consequences by creating rationales for their decisions or thoroughly assessing their co-workers. An example is when Clarissa reflected:

> *"I definitely feel anxiety too because the times that I knew that a song had a few cuss words or was a little risque for the unit I would kind of just be looking at the nursing station or like even walk over to the nurse's station and say, 'oh sorry'."*

Several other participants tried to maximize their agency through protecting themselves and preparing for potential questions. Other anecdotes illustrated ways that the participants tried to distance themselves from control by displacing responsibility onto clients or their work environment. Bloom shared:

> *"But well it's sort of a complex thing in terms of I don't feel that I would prefer somebody would watch me. I would prefer to be wearing a body cam. I would prefer to have all my sessions recorded. I would prefer for people to understand how there's a reason that you know, the self-proclaimed queer-dos of our adolescent unit are like thank God [Bloom] is*

here today. And they could emulate some of these skills that I bring if somebody cared to notice, you know what I mean?"

Bloom's response also highlights burnout other participants described as they detailed management observing select clinical choices, while management missed opportunities that demonstrated therapists' strengths and assets. Several participants acknowledged fear of complaints from their manager about noncompliance. Clarissa and Stella described fear of co-workers retaliating by reporting their actions to management. Diana however reported fear of direct retaliation from coworkers if she challenged the culture and status quo of her environment. She reflected on a peer who challenged officers in power, stating:

"Some of our staff that were more vocal about the treatment of the officers had their tires slashed. One had CPS called on her and they were going to take her kids away because she was reported as doing heroin in the car or something like that where someone called and made a false statement against her to try to have her kids taken away after she was vocal at work."

Fear of harm

In addition to fear of consequences, participants also described a fear of harm to themselves or clients through censorship practices or their decision making surrounding censorship. Within this sub-theme there were eleven different ways that participants detailed harm to the therapist (47 occurrences) and client (16 occurrences). These ranged from victim blaming at the participants' work environments to the belief that clients should be protected. Vincent shared an anecdote where co-workers consistently questioned the content of his group sessions, demonstrating the notion that clients need to be protected:

> *"Other staff started to note in my group, what are you doing to these girls? Every time after their group they're always triggered, after they leave your group they are always triggered and upset and crying."*

Alex reflected on their own censorship practices, describing times when clients can engage in a discussion of race in music, however, they stated: "*There are times where I will specifically censor songs that are being played by a white person that have the N word repeatedly."*

Some of the ways that participants described possible harm to clients included client discrimination, clients adapting to censorship practices, and the loss of potential connection to others through music. CeCe shared powerful dynamics at her work environment, detailing the power of co-workers:

> ***"****I have had interactions where I worry more about the staff retaliating against the youth because their own personal views, whether it's – I've heard all kinds-- you know, religious views, their own upbringing, bringing their own values on to the kids. And I've heard kids come back and say well, you know such and such told me that me saying that is not godly, it's not Christian to be saying these words at this age or just making them feel bad. So I've had actually more concerns about how some adults have pushed their own agendas on these youth and how that might be harmful versus me being worried about the language thing."*

Stella highlighted another example of harm to clients, stating:

> *"I'm realizing I've had more people triggered by the fact that I have to censor their music because there's the hospital policy to censor there to avoid triggering. But I have had people who have like directly been triggered by something in the content of music that*

I've brought in and definitely more of like it's definitely harder to work through that trigger-- if they're triggered by something that's in the lyrics or in the music itself."

Fear of Violence

In contrast to fear of harm to the therapist and client, many participants expressed an open fear of violence to themselves or others at the hands of clients. This differs from the previous sub-theme fear of harm as this is direct fear of physical bodily harm while the former encompassed emotional and relational harm. Clarissa summarized her work environment and the hyperfocus on safety, stating:

"Our main manager was an LCSW and would always say we've got to promote safety. So you just gotta shut it down. Let them know that it's about promoting safety and when they're outside of the hospital they can listen to the songs, but for here, it's about safety."

The notion of safety permeated all interviews as participants discussed their work environment, particularly when reflecting on the decision to censor or not. However, most participants acknowledged their work environment's focus on physical safety as opposed to emotional well-being, which became evident in displacing the need for control of clients onto the therapist. Stella and Diana both acknowledged balancing their personal safety through maintaining relationships with co-workers. Stella described this need as:

"*Yeah job security and job satisfaction-- it's feeling comfortable with other staff, I need to know working in psych… there's a lot of like unpredictability and I want to know that the other staff have my back and I have theirs"*

Diana also recognized unpredictability and the need to maintain relationships with co-workers stating: *"That's always in the back of my mind too if it ever comes down to that. How do I not ostracize myself so much from the people that would be saving my life."*

Fear of loss of therapeutic relationship

The final sub-theme within fear is the therapists' fear of losing the therapeutic relationship with clients as a result of censorship and work practices. This sub-theme was mentioned across all interviews and highlights participants' value and focus on the therapeutic alliance and relationship. Several clinicians described adaptations they added in an attempt to minimize the effects of censorship. This was evident in actions such as following up with clients after sessions, providing lyric sheets of the desired song, providing an individual session where clinicians have more freedom to play the song and relying on past interactions and established rapport if available. Clarissa reflected on the impact on herself, the relationship and follow-up steps, stating:

> *"I realized that I wanted to check in with them after to say hey, I apologize. I wasn't able to play your song. But would you want me to print out the lyrics for you so that even if you're not able to hear it, those words can still be in your hands*?"

Diana described the difficulty of balancing relationships with co-workers and clients, acknowledging the possibility of harming the therapeutic relationship by engaging with co-workers to complete necessary tasks for her job. Diana reflected:

> *"So we tried to keep good relationships with officers as much as possible which brought its own challenges because they were sometimes abusive to inmates. And so part of the*

inmates view of us was caring about their mental health if you're chummy with the officers. So it was a really really fine boundary. And how do I have a good enough relationship that I can get the equipment in that I want to use. That I can actually hold my groups, but I'm not seen as being too friendly with the officers that the inmates feel like they can open up to."

Theme 3: Inner responses in relation to music censorship

Table 5

Inner responses in relation to music censorship

a. emotional responses
b. somatic responses
c. psychological responses

Emotional responses

Participants reported a range of comfortable and uncomfortable emotions in response to censorship. Participants described comfortable emotions when they were able to engage in music uncensored, describing feeling *"excitement"*, *"relief," "cathartic"*, *"freeing,"* and, *"empowering."* Uncomfortable emotions were evident in fears of the therapist, such as fear of consequences, fear of harm, fear of violence, and fear of loss of relationship.

Somatic responses

Finally, therapists detailed many physical responses and sensations when experiencing censorship. These ranged from physical sensations such as feeling *"heavy,"* and, *"pressure,"* to physical behaviors and responses such as, *"brings a tear to my eye,"* and *"I've wanted to break something."* Overall, the majority of participants described strong somatic responses when enacting censorship practices, suggesting high levels of personal and professional discomfort at the possibility of enacting harm to clients through censorship practices.

Psychological responses

Many participants attempted to predict what co-workers or management would think if they heard an uncensored song. Participants often described decisions regarding censorship as, *"a cost-benefit analysis,"* which requires *"mental energy,"* and felt *"draining."*

Theme 4: Types of Censorship

The third core theme in the data was the various types of censorship at participants' work environments. There were various types of censorship practices ranging from administration blocking styles of music on streaming platforms to clinicians deciding to censor explicit content or lyric handouts. For the purpose of this study and lack of overall research on censorship, all examples will be included in this theme. This theme will be divided into two sub-themes: a) method of censorship, and b) content of music censored.

Method of censorship

Each participant acknowledged instances when they have censored by omitting or declining a client's request to hear a song due to their assessment and decision making relative to a group setting. This frequently occurred in relation to explicit lyrics, violence, and racial terms, which will be explored in the second sub-theme.

Table 5_Types of Censorship

4. Types of censorship
a. Method of censorship
b. Content of music censorship

Clarissa shared that her work setting omitted an entire genre of music which they deemed to be "inappropriate," or "unsafe," disproportionately affecting clients who prefer listening to rap music. She compared it to other styles, stating:

> *"There were metal songs that were literally Blood and Guts and those songs could play. I mean they were playing on YouTube, but when it came to like Ice Cube, 'have a good day,' such a great song, but that song wouldn't pop up on YouTube because it was censored."*

In addition to omission and administrative overreach, several participants shared that they also censored through altering lyric sheets and changing words for fear of the papers being discovered by co-workers or management. Vincent shared:

> *"I think the only censoring I would do would be in the written lyrics. I would hand out lyric sheets to songs that maybe they hadn't heard before that. I know there was cursing in the song or there was a use of the word n***** in the song. And so whenever I would type it up I will just go through and play with the words. So where there was a bitch I would write biz or where there was a n***a I would write ninja. And then like I would just say go through – like do word find – like search this word inside the document, find all these words, change all these words to this. And I will just go through and like change all the words and handle lyrics because at that point like if they had the lyric sheet outside the session that was out of my hands"*

While it was not addressed in depth, participants also discussed finding radio edits of songs as an adaptation to omitting the entire song. This is another form of censorship as words the artist wrote and intended were deleted if they were explicit, described violence, or referenced drugs or alcohol.

Content of Music Censored

All participants stressed the uniqueness of each censorship situation which may change based upon group members, staff members present, clients' histories or events that occurred

earlier in the day. For Stella, the ambiguity of censorship was also compounded by administrative policies that offered vague guidelines for decision making. Stella commented that the policy stated:

> *"If it is a level of an R-rated movie or above we can't really bring it in to group. So we gotta keep it PG-13 and under which music doesn't have the same rating system, so that's super ambiguous and they have decided that it is up to the music therapy department"*

Participants identified institutional and personal rationale for censorship based upon lyrical content such as swearing, violence, drug usage, and sexual content. Diana acknowledged the importance to maintain safety and order, per her work environment, stating she was unable to play: *"anything that was F the police. Anything that was glorifying drug abuse or violence and anything that was overtly sexual."* Participants identified the top reasons for censoring as sexual content (10 occurrences), drug usage (8 occurrences), violence in music (7 occurrences) and misogyny (2 occurrences). Notably, this disproportionately affected rap music for many participants; Clarissa reflected on her own experiences, stating: *"...having even a couple of patients say like you guys never play my music because my music is too black for you or that we only play country music or rock and roll."*

While rap music was frequently censored, CeCe and Stella discussed discrepancies in policies and environmental attitudes as they found similarities in thematic content between rap, country, or metal. CeCe stated:

> *"I've had lots of clients that listen to metal. What about topics of self-harm, do we censor that when we're talking about suicide and killing ourselves and things like that? And then using… So there's a lots of parameters around censorship that we should explore not just*

– I talk a lot more about the profanity piece, but there's lots more to explore and really defining what censorship means and what that is."

Stella acknowledged various obstacles when presenting music that addressed themes on marginalized identities, adding:

"It seems there's certain things that I've had to jump through hoops to get approved because it's things with lgbtq themes or racial themes that why is this not okay for us to discuss or bring into a group but some staff have had a problem with it in the past."

Theme 5: Impact of Other Professionals on Therapist's Decisions

The final core theme in the interview data describes participants' experiences in their work settings, featuring seven sub-themes that were mentioned 98 times in the interviews across the seven participants. The sub-themes described characteristics of co-workers and management, and other features such as a lack of trust in the work setting, colleagues' lack of awareness about the scope of practice of music therapists, victim blaming, and stereotyping and underestimating clients.

The most frequently discussed themes included a lack of trust in the work setting and a lack of understanding music therapy within the work culture, which was also evident in participants' view of their professional roles. This theme appeared throughout the interviews as participants described co-workers' apprehensions about the content of sessions and songs and clients' responses. The stated concern about clients' responses demonstrated that other professionals believed that the clients would be violent if they listened to certain songs, which both reinforces stereotypes and dehumanizes the clients. These concerns may also demonstrate environmental fears of violence and dehumanizing clients by focusing on their actions and fears. As a result, the participants felt greater responsibility for the song content utilized in sessions and

the impact it would have on the clients. Diana reflected on playing songs with sexual content and a co-worker telling her, *"it's not appropriate, if you get sexually assaulted it's your fault, you know."* While Diana's colleagues displaced responsibility onto her, Alex reflected on their co-workers' tendency to make decisions based upon fear and a lack of knowledge of what music therapists do. Alex described a pattern of such interactions with co-workers, stating:

> *"I've also had people you know, when we're getting into a heavy discussion, I've had staff members say oh this isn't a process group. So I think there might be some fear that things are gonna go to a place that they don't necessarily trust just from, you know, lack of awareness of what we do. We might be [...] concerned about [...] the same thing. Then just reassure them I got it."*

Notably, several therapists described feeling the need to justify their clinical decisions and qualifications to co-workers. Having to repeatedly justify oneself to coworkers can contribute to isolation from co-workers and even lead to burnout, as was shared by some participants. Every participant acknowledged having different philosophies and approaches regarding censorship than their co-workers or management, which often led to education and advocacy for the profession and clients. Vincent reflected on censorship practices at his workplace and his views about co-workers infantilizing clients, stating:

> *"I remember there being some initial resistance… you act as though they don't know what the curse word is in the first place. Nothing is being changed here. But the only thing that's happened is they're thinking that they're censored and they can't say things. They're going to curse when they get mad."*

In addition to a general lack of trust for the therapist, clients were not trusted to make their own decisions and were often viewed through a lens of fear and immaturity. Clarissa highlighted the accumulation of her advocacy for clients and discussions with management. She said:

> *"I was just getting the burnout because I was just so tired of fighting for patient rights, for human rights, you know, I was just so tired of having people telling me no and when I would ask why, it was just we already said no. And so I had moved past the anxiety part into the I just am frustrated and then I just don't tell anything, I'm not going to ask him just going to do and I'll apologize after and then I would kind of try and talk with them about it and just not really finding any common ground. So I just would do and hopefully nobody said anything."*

Discussion

This study sought to learn and make sense of music therapist's experiences in a setting that values censorship and the impact of censorship on therapist's' perceptions of self-efficacy and their relationships with clients and colleagues. Interview questions utilized qualities of interpretivist phenomenological analysis (IPA), such as focusing on physical experiences, thoughts, and emotions when participating in censorship practices or engaging in discussions with colleagues about censorship. This study also explored participants' responses to systemic work values that differ from the clinicians' and the subsequent effects on their self-concept and clinical relationships. Participants shared narratives that outlined a variety of complex personal responses such as fear, guilt, and conflict regarding their clinical decisions and role in their work environment and health-care system.

As a music therapist, I have had my own experiences with censorship that led to this topic and thesis. As the researcher, it was my objective to acknowledge and honor others' experiences with censorship without projecting my complex responses and emotions. Given the diversity of participant work environments, years of practice, and sociocultural identities, I was struck by the similarities of our experiences, particularly physical and emotional responses and ways the therapist adapted. There were moments where it felt as though I was hearing my own experience as participants recounted personal and professional difficulties with honesty and

openness. I feel humble and grateful for participants' vulnerability in discussing this topic and hope it advances discussion on censorship in music therapy.

As participants discussed and identified the nuances of censorship, I was struck by the degree of self-reflection and critical thinking required to decide to set boundaries or censor songs based upon group needs. Since this topic is situated in the culture of each group and individual experience, navigating censorship issues may feel overwhelming for music therapists. Moving forward, it is important for the music therapy community to address the nuance of censorship through additional research, training, and peer support to acknowledge the harm censorship may cause to the client and therapist.

Beliefs and values in music therapy

The music therapy community acknowledges the importance of cultural responsiveness and reflexivity (Rolvsjord & Stige, 2015; Ghetti, 2020; Scrine & McFerran, 2018), and this opinion was shared by the participants. As a result of cultural responsiveness, there have been discussions on the impact of the social location of the therapist and the value of working from a culturally sustainable and anti-oppressive lens (Baines & Edwards, 2018; Ghetti, 2020, Hadley, 2021). However, research on harm and oppression caused through censorship practices is minimal, with my search only finding Joplin's 2017 survey on censorship.

Consistent with the findings Joplin (2017) reported from her survey respondents, the participants in this study reported that they may engage in censorship due to institutional policies or to maintain group safety. In her study, Joplin (2017) identified internal causes of censorship, stating, "Approximately 25% of participants reported personal reasons, such as their comfort level with the content, religious beliefs, and believing the client cannot benefit from hearing the content" (p.199) . External forces that encourage censorship and the personal reasons that

therapists engage in censorship practices censorship reveals the similarities and differences of values amongst therapists and the institutions they work for. Throughout the interviews, participants utilized terminology such as, "*glorifying,"* or *"promoting,"* content when describing environmental values and policies, in addition to limits in personal comfort with song content and lyrics. Therapist's values of freedom of expression and safety were evident in the interviews as several participants identified conflicting emotions and cognitive dissonance regarding setting boundaries through censoring or not playing songs with sexual content, racial terms, and violent content.

Additionally, many participants focused on the role of therapist to ensure group and individual safety within the musical space when deciding whether or not to play a particular song. It is crucial for clinicians to reflect on the motivation for the choice and focus on safety of all clients. Therapists may engage in hierarchical thinking in terms of their beliefs and values in relation to the clients' or may hold infantilizing views about the clients. This was noted as several participants discussed their role as, *"keeping the group safe."* When discussing safety, participants acknowledged the duality of censorship, as some clients may experience harm from uncensored music, while others may experience rejection and harm from music that is censored. Murakami (2021) notes this complexity in the six situations she outlines when clients may experience harm. Murakami (2021) writes, "these same factors are theorized to act as protective elements that allow music therapists to remediate instances of harm and promote client resilience in the face of negative music therapy experiences" (n.p.). These conflicting scenarios also relate to the central value of nonmaleficence and doing no harm to clients, as outlined in the music therapy code of ethics. However, structuring for safety in music

therapy practice may produce a sense of dissonance or confusion for the clinician due to the vastly different clinical outcomes of censorship.

In addition, participants noted that the values of other professionals in the work setting contributed to conflicting or ambiguous policies under the guise of stressing safety for group members. These policies demonstrate mandatory ethics which emphasize dichotomous thinking in terms of "appropriate" or "inappropriate" music. This thought pattern was noted throughout participant interviews as they acknowledged the discrepancy of administrative responses and policies on rap music compared to country or metal which had similar thematic content. Every participant addressed racial elements in censorship and administrative responses that focused primarily on rap music. One participant expressed, *"I think when it comes to censorship, especially when it comes to rap music, it's mainly because it's just not a very explored genre of music"*. While this may be true, Schneider (2011) discusses the necessity of including hip-hop and rap music in culture, stating:

> This cultural space (e.g. hip-hop) allows for the development of a privileged everyday life to those who do not have one and for the opportunity to better improve and make sense of the chaos (e.g., violence, marginalization, subordination, oppression) that is, for many, everyday life. (p. 40).

Anti-Black Racism in Censorship Practices

It is important to note the many overt and covert examples of anti-Black racism throughout the interviews and participants' experiences. This was noted on an overt and institutional level as one participant's administration censored an entire genre and culture of music, as Clarissa recounted: *"I literally am not letting you express who you are in your life because the hospital tells me I can't play the song plus--also , literally, YouTube was censoring all rap music."* On a

covert level, many participants identified institutional and personal rationale for censorship based upon lyrical content such as profanity, violence, drug usage, and sexual content. Participants identified the top three reasons for censoring as sexual content (10 occurrences), drug usage (8 occurrences), and violence in music (7 occurrences). These labels have been used as covert racial codes notably since in the 1950s when powerful, white, Christian music executives posited that Black music was too sexual, or later became too violent (Chastagner, 1999). Through radio censorship practices and cultural norms, the dominant group maintained their power through gatekeeping practices and dichotomous labeling of, "appropriate," or, "inappropriate" music. This anti-Black racism in the censorship practices was apparent as participants identified the inconsistencies between rap music and country or metal music that included similar content in terms of descriptions of violence, substance use, sexual content and misogyny. These disparities were evident in the literature as Norris (2020) discussed the importance of recognizing ways music therapy may advance or perpetuate anti-black racism and oppression.

Responses to Censorship Policies

Due to the interpretivist design of this study, participants reflected primarily on their own experiences and recounted personal stories about clients, co-workers, and work environments. Many participants described the need to constantly adapt songs or lyric sheets to protect clients and themselves based upon staff and workplace dynamics.

Furthermore, many therapists took proactive steps to ensure they were following institutional policies and could subsequently evade consequences in an effort to protect their jobs/themselves. For several participants this involved writing a rationale for the use of different kinds of music or purposefully selecting music that complied with workplace policies and culture. One participant described their attitude when writing rationales to protect themselves,

stating it is a, *"feeling like I'm BS-ing my way through, I have to kind of write to do this and play this game."* These processes that involve proactively objecting to censorship policies and practices, the constant preparation needed to navigate these situations, and the perceived lack of autonomy that music therapists experience when it comes to music selection practices all contribute to burnout and fatigue (Kim, 2012; Vega, 2010.) Additionally, the frequency of with which participants felt the need to write a rationale for music selection may suggest a hypervigilant response as they attempted to avoid future consequences and ensure personal and group safety.

Participants justified their decisions regarding censorship. Interestingly, there were several instances when participants reportedly apologized to clients about the institution's policies. In addition to justifying decisions and apologizing, participants also advocated for client rights and listened to preferred and culturally relevant music. As participants reflected on clinical and professional relationships, participants spoke most extensively on clients' emotional, verbal, cognitive and physical responses. Given the data, it appears participants perceive clients responding emotionally to censorship compared to other responses. This may be consistent with psychodynamic approaches that emphasize client transference and projection techniques in song discussions (Bruscia, 1998; Dvorak, 2017; Gardstrom & Hiller, 2010).

Navigating Power

Each participant outlined a variety of ways they share power and strive to work in a just manner that acknowledges client autonomy and power. Participants described the importance of sharing power through honoring clients' experiences that are represented in their music and offering opportunity for choices and autonomy. Across the narratives and interviews, many participants reflected on their own social location and intersecting identities in relation to clients

and music. Several participants acknowledged the culture of their settings, engrained hierarchies, and institutional elements such as racism and sexism. As such, by acknowledging individual and systemic oppression, these participants seem to practice from an anti-oppressive stance. Anti-oppressive practice acknowledges the impact of harmful systems and oppression based on, "age, class, ethnicity, gender identity, geographic location, health, ability, race, sexual identity, and income and that personal troubles are seen as inextricably linked to these oppressive structures" (Baines, 2011, p. 2). However, it is also important to acknowledge less altruistic motivations of anti-oppressive action, such as white guilt or feeling the need to save or protect clients. It may be that some of these motivations were present for some of the participants in the current study. This has been underexplored in literature and it would be beneficial for research in music therapy to explore this.

Need for music therapy research, education, and training

The lack of research, and education and training, on censorship in music therapy permeated participant interviews and experiences. This is evident as one participant described their experience with censorship as *"something that I just learned on the fly."* One participant reflected on their undergraduate education and internship experience, expressing disappointment that it was not covered or at least acknowledged. Several participants expressed relief and support by simply engaging in this interview and discussing censorship practices. One participant stated, *"you're not the only one going through it. You're not the only one who deals with this and you know what, I don't know validating, yeah, it's nice to know that other people experience it as well."* Each therapist discussed the need for professional support and a broader discussion amongst the music therapy community regarding the nuance of censorship practices.

Therapists expressed the need for continued discussion due to the longevity and relevance of censorship. This was noted as Stella stated:

> *"there's always going to be some genre of music that some group of people vilifies and so it's not like this is just going to be an issue this year, this generation. This is a lifelong issue. So as a profession, it'd be nice to have some open and authentic discourse about something that's likely going to continue to affect our profession for long-term."*

Study Limitations

Despite a range of work settings and sociocultural diversity of participants, there is the potential that this research may not be relevant or useful to broader music therapy communities due to the research design and unique lived experience of each participant. However, given the shared themes that permeated the interviews of all of the participants, it is my hope that it will be applicable for music therapists working in mental health facilities. Participants were purposefully selected to include as many different identities as able due to the political nature of censorship. However, this does not represent all music therapists' experiences and thus may limit the themes that emerged. In addition, the sample size was limited to seven participants due to the research design and need for depth. Participants' identities did not include disabled or trans identities, among others, thus did not represent the identities of all music therapists and their lived experiences regarding censorship. Additionally, my social location as a cis-woman who is white and nondisabled limited my analyses and interpretations in this research as I have my own interactions with censorship affected by my intersecting identities.

Recommendations for Future Research

Participants in this study identified the need for additional research on censorship in music therapy. Future research could explore therapists' experiences with censorship as a means of validating and clarifying existing information. Within the seven interviews there were different views and means of censorship, thus it would be beneficial for music therapists to learn more about the effects of different censorship practices, such as censoring lyric sheets, playing, "radio" versions of songs, omitting songs based upon content, or banning entire genres of music. Furthermore, future research should strive to examine clients' experiences and responses to censorship as every research participant shared many narratives and interactions with clients through their own perspectives. Future qualitative research may examine the impact of censorship on clients' self-concept as a result of the messages they receive from their music being censored or not played. This is relevant as several reasons for censorship can be covert anti-Black values, in addition to signaling that clients' experiences are not "appropriate" or accepted.

In addition to client experiences, future research should strive to include additional settings that may be overlooked for censorship, such as older adults. It may be important to consider music therapist attitudes toward clients in different settings with censorship, as some individuals may be infantilized, overprotected, or ignored.

Every participant acknowledged the need for discussion of censorship in music therapy education and supervision. While more research is needed, it may be premature or limiting to develop a framework for censorship, due to the nuances of censorship. These nuances are specific to the culture and needs of each group member and the therapist.

Conclusion

The present research study examined the effects of institutional values of censorship on therapist's relationships and self-concept. This study demonstrated various harmful responses to the therapist and client as a result of censorship practices and related environmental values. When discussing their experiences, participants identified a variety of responses that are suggestive of burnout such as personal and professional dissonances and many fear-based responses. The literature on burnout notes that lack of support from management and strained relationships with co-workers are a major source of burnout (Vega, 2010; Kim, 2011). Participants described personal conflicts and dissonance, in addition to a variety of fears relative to censorship in their work environments and navigating collegial and administrative relationships.

Each participant organically engaged in self-reflection throughout the interviews and identified ways to share power with participants and address various responses to censorship. Many of these responses echoed tenets of anti-oppressive practice such as self-reflection, recognizing the social location of the therapist and acknowledging dynamics of broader systems in clients' lives such as racism in the institution or sexism with male staff members (Baines, 2012; Ghetti, 2020; Scrine & McFerran, 2018). Participants also acknowledged many adaptations and additional roles they took on such as an advocate for clients, or educator for co-workers and administration.

Many participants acknowledged the lack of research and discussion within the music therapy profession on censorship practices. However, these interviews demonstrate the importance of dialogue as therapists reported feeling *"excited"* for the topic to be explored, in addition to feeling less alone. Engaging in authentic discussion on the cultural implications of

censorship acknowledges the injustices and harm that clients may experience within music therapy while simultaneously challenging therapists to do better. As a profession that values nonmaleficence, it is imperative that therapists examine ways their practice may be oppressive and enacting harm (Baines, 2011; Ghetti, 2020; Norris, 2020).

Overall, participants in this study described the nuance of censorship and the related difficulties through responses and relationships. First, as participants suggest, the wider music therapy community must engage in discourse related to the effects of censorship and harm that may occur to clients and therapists. As participants addressed, it is also crucial for music therapists to engage in self-reflexivity concerning the effects of their intersectional identities on the therapeutic relationship and clinical decision making. One possibility could be engaging in supervision specific to culturally responsive practices or anti-oppressive practice to ensure accountability and reflexivity. This will likely involve discomfort for the clinician and require a lifelong dedication to unlearning dominant narratives, in addition to recognizing implicit bias and values. More discussions, supervision, and training need to be offered to professionals to challenge personal biases and equip therapists as client advocates and allies against institutions of oppression.

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Appendix A

Call to Research

To Board-Certified Music Therapists:

My name is Emily Boyce and I am a current candidate for Slippery Rock University's Master of Music Therapy program. My thesis, How music therapists experience their relationship to self and others when working in a setting that values censorship, is currently being conducted under the direction of Susan Hadley, Ph.D, MT-BC. This study intends to explore censorship regulations and practices in mental health settings and its effects on therapists, their clinical and professional relationships. Research participants will be asked to participate in one semi-structured Zoom interview, which will be recorded and used for data analysis. If you are interested please fill out this google form with various demographic and professional questions.

Appendix B

Participant Demographic Questions

Name and pronouns:

What is your email address:

What is your gender identity:

What is your race:

What setting of mental health do you work:

- Inpatient hospital
- Outpatient services
- Partial hospitalization
- Drug and alcohol settings
- Forensic settings
- Other:

How long have you practiced music therapy:

- 1-5 years
- 5-10 years
- 10+ years

Do you work with adults in mental health:

- Yes
- No

Do you work in a setting that enforces censorship in music:

- Yes
- No

Appendix C

Consent Form

Copy of
Master_consent_for

Appendix D

Interview Questions

1. Tell me a story about a memorable song discussion from a group.

2. In what ways does your facility impose limitations about what can be brought into sessions?

   a. Funnel question: is it written policy, verbal expectations, etc.
   - What do you change about structuring song discussions as a result?
   - How do you feel about these limitations?

3. When you engage in censoring music how do you feel about yourself as a clinician?

   - What are you most aware of? (physical response, maintaining the relationship with clients, your social location, etc.)
   - What are some ways clients may view you and your role?

4. What might some responses or reactions from clients and co-workers be if you brought in un-censored music?

5. Have you ever taken a risk bringing a song into a session where someone may judge you?

   - what did you feel in your body?
   - where did your thoughts go?
   - what are some of your anxieties or fears?

6. What are some memorable interactions with clients when you censored music?

- What was your initial reaction? (Feeling in body, thoughts, emotions)
- How does this relate to your social location in the therapy space?

7. Tell me a story about a time you wanted to bring in a song to a session, but couldn't. What was that like?

8. After reflecting on these memories and experiences, what stands out to you? Any emotional or physical responses?